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SAN BERNARDINO COUNTY

Department of Behavioral Health
Substance Use Disorder and Recovery Services

San Bernardino County DBH-SUDRS CalOMS Admission

First Name			**Last Name**		
Current First Name			**Current Last Name**		
Social Security Number		**ZIP Code**		**Place of Birth (County)**	
Place of Birth (State)		**Driver's License Number**		**Driver's License State**	
Mother First Name			**Client ID**		
Counselor Name			**Date**		

Race

Please select each of the client's races. You may check up to 5 boxes (check appropriate boxes):

☐Hawaiian ☐Japanese ☐Korean ☐Laotian
☐Samoan ☐Vietnamese ☐Other Asian ☐Other Race
☐Multi-Racial ☐White/Caucasian ☐Black/African-American
☐American Indian ☐Asian Native ☐Asian Indian ☐Cambodian
☐Chinese ☐Filipino ☐Guamanian

Ethnicity

Please select client's ethnicity (check appropriate box):

☐Not Hispanic
☐Mexican/Mexican American
☐Cuban
☐Puerto Rican
☐Other Hispanic/Latin

Veteran

Please select the client's veteran status (check appropriate box):

☐ No ☐ Yes ☐ Client declined to state ☐ Client unable to answer

Disability

Please select the client disability (check appropriate box):

☐None
☐Visual
☐Hearing
☐Speech
☐Mobility
☐Mental
☐Developmentally Disabled
☐Other
☐Client declined to state
☐Client unable to answer

Consent

Please select **Yes or No** if the client has given consent to be contacted in the future (check appropriate box):

☐ Yes ☐ No

Transaction

Admission Transaction

Please select the type of admission (check appropriate box):

☐Initial Admission

☐Transfer of change in service

Admission

Source of Referral

Please select the referral source (check appropriate box):

Ask: What is your principal source of referral?

☐Individual includes self-referral

☐Alcohol/Drug abuse program

☐Other health care provider

☐School/Educational

☐Employer/EAP

☐12 Step Mutual Aid

☐SACPA/Prop 36/OTP/Probation or Parole

☐Post-release Community Supervision (AB 109)

☐DUI/DWI

☐Adult Felon Drug Court

☐Dependency Drug Court

☐Non-SACPA Court/Criminal Justice

☐Other Community Referral

☐ Dependency Court/Child Protective Services

Days Waited to Enter Treatment

Please enter the total number of days (not including any time incarcerated), the client was on a waiting list before being admitted into a treatment program.

Ask: How many days were you on a waiting list before you were admitted to this treatment program? _____

Number of Prior Episodes

Please enter the total number of episodes the client has participated in treatment as a primary client, not as a codependent.

Ask: What is the number of prior episodes in any alcohol or drug treatment/recovery program in which you have participated?

_____

CalWORKs Recipient

Please select **Yes or No** if the client is a CalWORKs recipient(check appropriate box):

Ask: Are you a CalWORKs recipient?

☐ Yes ☐ No

Substance Abuse Treatment Under CalWORKs

Please select **Yes** if the client received substance abuse treatment under CalWORKs (check box):

Ask: Are you receiving substance abuse treatment services under the CalWORKs welfare-to-work plan?

☐ Yes ☐ No

Special Services Contract County Code

Please select **Yes or No** in the special services contract county (check appropriate box):
☐ Yes ☐ No

Special Services Contract ID

Please enter the contract ID _____
Enter **99902** or the **Special Services Contract County Code if applicable.**

Alcohol and Drug Use

Primary Drug
Please select the client's primary drug of use (check appropriate box):
If **Other (Specify)** is selected, enter the name of the client's primary drug in the **Primary Drug Name**.

Ask: What is your primary alcohol or other drug problem?

☐Alcohol
☐Barbiturates
☐Cocaine/Crack
☐Ecstasy
☐Heroin
☐Inhalants
☐Marijuana/ Hashish
☐Methamphetamines
☐Non-Prescription Methadone
☐None
☐Other (specify) _____
☐Other Amphetamines
☐Other Club Drugs
☐Other Hallucinogens
☐Other Opiates and Synthetics
☐Other Sedatives or Hypnotics
☐Other Stimulants
☐Other Tranquilizers
☐Over-the-Counter
☐OxyCodone/OxyContin
☐PCP
☐Tranquilizer (Benzodiazepine)

Primary Drug Frequency
Please enter the drug use frequency.

Ask: How many days in the past 30 days have you used your primary drug of abuse? _____

Primary Drug Route of Administration
Please select the client's primary drug route (check appropriate box):

Ask: What usual route of administration do you use most often for your primary drug of abuse?

☐Oral
☐Smoking
☐Inhalation
☐Injection (IV or intramuscular)
☐ None or Not Applicable
☐Other

Primary Drug Age of First Use
Please enter the client's age at the time of first drug use.

Ask: At what age did you first use your primary drug of abuse? _____

Secondary Drug
Please select the client's secondary drug of use (check appropriate box):
If **Other (Specify)** is selected, enter the name of the client's secondary drug in the **Secondary Drug Name.**

Ask: What is your secondary alcohol or other drug problem?

☐Alcohol
☐Barbiturates
☐Cocaine/Crack
☐Ecstasy
☐Heroin
☐Inhalants
☐Marijuana/ Hashish
☐Methamphetamines
☐Non-Prescription Methadone
☐None
☐Other (specify) _____
☐Other Amphetamines
☐Other Club Drugs
☐Other Hallucinogens
☐Other Opiates and Synthetics
☐Other Sedatives or Hypnotics
☐Other Stimulants
☐Other Tranquilizers
☐Over-the-Counter
☐OxyCodone/OxyContin
☐PCP
☐Tranquilizer (Benzodiazepine)

In the **Secondary Drug Frequency**
Please enter the drug use frequency.

Ask: How many days in the past 30 days have you used your secondary drug of abuse? _____

In the **Secondary Drug Route of Administration**
Please select the client's secondary drug route (check appropriate box):

Ask: What usual route of administration do you use most often for your secondary drug of abuse?

☐Oral
☐Smoking
☐Inhalation
☐Injection (IV or intramuscular)
☐None or Not Applicable
☐Other

Secondary Drug Age of First Use
Please enter the client's age at the time secondary drug use began.

Ask: At what age did you first use your secondary drug of abuse? _____

Alcohol Frequency
Please enter the frequency of alcohol use in the last 30 days. This field is used when the primary and secondary drugs are not alcohol.

Ask: How many days in the past 30 days have you used alcohol? **_____**
If the participant's primary or secondary drug problem is alcohol, enter 99902.

IV Use
Please enter the frequency of the IV use.

Ask: How many days have you used needles to inject drugs in the past 30 days? _____

Needle Use in the Last 12 Months
Please select **Yes or No** if the client has used a needle drug in the last 12 months(check appropriate box):

Ask: Have you used needles to inject drugs in the past twelve months?
☐ Yes ☐ No

Employment

Enrolled in School
Please select the client's enrollment status (check appropriate box):

Ask: Are you currently enrolled in school?
☐ No ☐ Yes ☐ Client declined to state ☐ Client unable to answer

Highest School Grade Completed
Please enter the client's highest school grade completed.

Ask: What is the highest school grade you completed? _____
Enter "**99900**" to indicate that the client declines to state
Enter "**99904**" to indicate that the client is unable to answer.

Employment Status
Please select the client's employment status (check appropriate box):

Ask: What is your current employment status?
☐Employed Full Time (35 hours or more)
☐Employed Part Time (less than 35 hours)
☐Unemployed Looking for Work
☐Unemployed – (Not seeking)
☐Not in the labor force (Not seeking)

Enrolled in Job Training
Please select the client's job training status (check appropriate box):

Ask: Are you currently enrolled in a job training program?
☐ No ☐ Yes ☐ Client declined to state ☐ Client unable to answer

Work Past 30 Days
Please enter the number of work days the client has had in the past 30 days.

Ask: How many days were you paid for working in the past 30 days? _____

Criminal Justice

Criminal Justice Status
Please select the client's criminal justice status (check appropriate box):

Ask: What is your criminal justice status?
☐No criminal justice involvement
☐Under parole supervision by CDC
☐On parole from any other jurisdiction
☐Post-release Community Service (AB 109) or on probation from any federal, state, or local jurisdiction
☐Admitted under diversion from any court under CA Penal Code Section 1000
☐Incarcerated
☐Client unable to answer
☐Awaiting trial, charges, or sentencing

CDC Identification Number
Please enter the client's California Department of Corrections (CDC) identification number.

Ask: What is your CDCR number? **_99902_**
* **Response will always be 99902**

Number of – Please enter the number of times the client has been involved with the specified activity in the last 30 days.

Ask: How many days in the past 30 days were you in jail? _____

Ask: How many days has the client been in prison in the past 30 days? _____

Ask: How many times have you been arrested in the past 30 days? _____

Parolee Services Network (PSN)
Please enter the client's Parolee Services Network status.

Ask: Are you a parolee in the PSN program? **No** * **Response will always be No**

FOTP Parolee
Please enter the client's Female Offender Treatment Program (FOTP) status.

Ask: Are you a parolee in the Female Offender Treatment Program (FOTP)? **No** * **Response will always be No**

FOTP Priority Status
Please enter the client's FOTP priority status.

Ask: What is your FOTP priority status? **None** * **Response will always be None or Not Applicable**

Medical/Physical Health

Medi-Cal Beneficiary
Please select whether the client is a Medi-Cal beneficiary (check appropriate box):

Ask: Are you a Medi-Cal beneficiary?
☐ No ☐ Yes ☐ Client unable to answer

Last 30 Days
Please enter the number of times the client has been involved with the activity in the last 30 days.

Ask: How many times have you visited an emergency room in the past 30 days for physical health problems? _____

Ask: How many days have you stayed overnight in a hospital in the last 30 days for physical health problems? _____

Ask: How many days in the past 30 days have you experienced physical health problems? _____

Pregnant At Admission
Please select **Yes, No or Not Sure/Don't Know** if the client was pregnant at the time of admission (check appropriate box):

If the client is not male, at admission, **Ask**: Are you pregnant?
☐ Yes ☐ No ☐ Not Sure/Don't know

Medication Prescribed As Part of Treatment
Please select the medication prescribed for the client as part of treatment (check appropriate box):

This field is not intended to capture the individual's prescriptions for non-addiction treatment purposes, so providers should only report those medications prescribed by the provider for SUD treatment. In addition, this field is checked against the Master Provider File (MPF). This is to ensure the services being reported are consistent with what the provider is certified or licensed to provide:

☐None
☐Methadone
☐LAAM
☐Buprenorphine (Subutex)
☐Buprenorphine (Suboxone)
☐Other

Communicable Diseases
Please select the client's status with the disease (check appropriate box):

Ask: Have you been diagnosed with Tuberculosis?
☐ No ☐ Yes ☐ Client declined to state ☐ Client unable to answer

Ask: Have you been diagnosed with Hepatitis C?
☐ No ☐ Yes ☐ Client declined to state ☐ Client unable to answer

Ask: Have you been diagnosed with any sexually transmitted diseases?
☐ No ☐ Yes ☐ Client declined to state ☐ Client unable to answer

HIV Tested
Please select the client's HIV testing status and results (check appropriate box):

Ask: Have you been tested for HIV/AIDS?
☐ No ☐ Yes ☐ Client declined to state ☐ Client unable to answer

Ask: Did you receive the results of your HIV/AIDS test?
☐ No ☐ Yes ☐ Client declined to state ☐ Client unable to answer

Mental Illness

Mental Illness
Please select **Yes, No or Not Sure/Don't Know** if the client has mental illness (check appropriate box):

Ask: Have you ever been diagnosed with a mental illness?
☐ No ☐ Not Sure/Don't know ☐ Yes

Emergency Room Use/Mental Health

Ask: How many times in the past 30 days have you received outpatient emergency services for mental health needs? _____

Psychiatric Facility Use
Please enter the number of days in the last 30 days the client has stayed for more than 24 hours in a hospital or psychiatric facility.

Ask: How many days in the past 30 days have you stayed for more than 24 hours in a hospital or psychiatric facility for mental health needs? _____

Mental Health Medication
Please indicate the client's mental health prescription medication use in the last 30 days.

Ask: In the past 30 days, have you taken prescribed medication for mental health needs? _____

Family/Social

Social Support
Please enter the number of days in the last 30 days the client has participated in social support recovery activities.

Ask: How many days have you participated in any social support recovery activities in the past 30 days such as 12-step meetings, other self-help meetings, religious/faith recovery or self-help meetings, meetings of organization other that those listed above, interactions with family members and/or friend support of recovery? _____

Current Living Arrangements
Please select the client's current living arrangements (check appropriate box):

Ask: What are your current living arrangements?

☐ Homeless
☐ Independent Living
☐ Dependent Living

Living with Someone
Please enter the number of days in the last 30 days the client has lived with someone who uses alcohol or drugs.

Ask: How many days in the past 30 days have you lived with someone who uses alcohol or other drugs? _____

Family Conflict Last 30 Days
Please enter the number of days in the last 30 days the client had serious conflicts with their family.

Ask: How many days in the past 30 days have you had serious conflicts with members of your family? _____

Number of Children
Please enter the **number** of children associated with the client.

Ask: How many children do you have aged 17 or younger (birth or adopted) whether they live with you or not? _____

Ask: How many children (birth or adopted) do you have aged five years or younger? _____

Ask: How many of your children (birth or adopted) are living with someone else because of a child protection court order? _____

Ask: If you have children (birth or adopted) living with someone else because of a child protection court order, for how many of these children aged 17 or under have your parental rights been terminated? _____

Emergency Contact Information

Emergency Contact
Please enter the emergency contact information.

Emergency Contact Living with Client (check appropriate box):
☐ Yes ☐ No

Please enter Emergency Contact Name _____

Please enter Emergency Contact Phone Number_____

Please enter Emergency Contact City_____

Please enter Emergency Contact State_____

Please enter Emergency Contact Zip Code _____

Please select Emergency Contact Relationship (check appropriate box):

☐Aunt	☐Grandmother	☐Sister
☐Brother-In-Law	☐Grandson	☐Step-Brother
☐Brother	☐Guardian	☐Step-Father
☐Cousin	☐Mother-In-Law	☐Step-Mother
☐Father-In-Law	☐Mother	☐Step-Sister
☐Father	☐Nephew	☐Uncle
☐Friend	☐Niece	☐Unknown
☐Granddaughter	☐Other Family Member	
☐Grandfather	☐Sister-In-Law	

San Bernardino County DBH-SUDRS CalOMS Admission - Instructions

Please **ask** all the questions provided in this packet and enter them appropriately. Please solicit enough information from the client and document that information thoroughly to ensure all the appropriate information is collected.

Client Information

Enter Birth First Name. Please enter the client's first name at birth.
• Enter "**99902**" if the client does not have a birth first name.
• Enter "**99904**" if the client is unable to provide an answer.

Birth Last Name. Please enter the client's last name at birth.
• Enter "**99904**" if the client is unable to provide an answer.

Current First Name. Please enter the client's first name if different from the birth name.
• Enter "**99904**" if the client is unable to provide an answer.

Current Last Name. Please enter the client's last name if different from the birth name.
• Enter "**99904**" if the client is unable to provide an answer.

Social Security Number. Please enter the client's social security number.
• Enter "**99900**" to indicate that the client declines to state their social security number.
• Enter "**99904**" to indicate that the client is unable to answer.

ZIP Code At Current Residence. Please enter the client's ZIP code.
• Enter "**00000**" to indicate that the client is homeless and update the **Current Living Arrangements** on the **Family/Social** section accordingly.
• Enter "**99900**" to indicate that the client declines to state their ZIP code.
• Enter "**99904**" to indicate that the client is unable to answer.

Place of Birth – County. Please select the county from the list.
• Choose **Other** if the client was born outside California.

Place of Birth – State. Please select the client's place of birth.

Driver's License Number. Please enter the client's driver's license.
• Enter "**99900**" to indicate that the client declines to state their driver's license number.
• Enter "**99902**" to indicate that the client has no or no applicable driver's license number.
• Enter "**99904**" to indicate that the client is unable to answer.

Driver's License State. Please enter client's state.

Mother's First Name. Please enter the client's mother's first name.

Counselor Name - Please enter the name of the counselor who completed this packet.

Date - Please enter the date the packet is being completed.

Demographics

Race. Please select each of the client's races. You may check up to 5 boxes.

Ethnicity. Please select the client's ethnicity.

Veteran. Please select the client's veteran status.

Disability. Please select the client disability.

Consent. Please select **Yes or No** if the client has given consent to be contacted in the future.

Transaction

Admission Transaction. Please select the type of admission.

Admission

Source of Referral. Please select the referral source.

Days Waited to Enter Treatment. Please enter the total number of days (not including any time incarcerated), the client was on a waiting list before being admitted into a treatment program.

Number of Prior Episodes. Please enter the total number of episodes the client has participated in treatment as a primary client, not as a codependent.

CalWORKs Recipient. Please select **Yes or No** if the client is a CalWORKs recipient.

Substance Abuse Treatment Under CalWORKs. Please select **Yes** if the client received substance abuse treatment under CalWORKs.

Special Services Contract County Code. Please select **Yes or No** in the special services contract county.

Special Services Contract ID. Please enter the contract ID.
• Enter "**99902**" or the **Special Services Contract County Code if applicable.**

Alcohol and Drug Use

Primary Drug. Please select the client's primary drug of use.
If **Other (Specify)** is selected, enter the name of the client's primary drug in the **Primary Drug Name**.

Primary Drug Frequency. Please enter the drug use frequency.

Primary Drug Route of Administration. Please select the client's primary drug route.

Primary Drug Age of First Use. Please enter the client's age at the time of first drug use.

Primary Drug Age of First Use. Please enter the client's age at the time of first drug use.

Secondary Drug. Please select the client's secondary drug of use.
If **Other (Specify)** is selected, enter the name of the client's secondary drug in the **Secondary Drug Name.**

Secondary Drug Frequency. Please enter the drug use frequency.

Secondary Drug Route of Administration. Please select the client's secondary drug route.

Secondary Drug Age of First Use. Please enter the client's age at the time secondary drug use began.

Alcohol Frequency. Please enter the frequency of alcohol use in the last 30 days. This field is used when the primary and secondary drugs are not alcohol.
• Enter "**99902**" **if the participant's primary or secondary drug problem is alcohol.**

IV Use. Please enter the frequency of the IV use.

Needle Use in the Last 12 Months Please select **Yes or No** if the client has used a needle drug in the last 12 months.

Employment

Enrolled in School. Please select the client's enrollment status.

Highest School Grade Completed. Please select the client's highest school grade completed.
- Enter "**99900**" to indicate that the client declines to state.
- Enter "**99904**" to indicate that the client is unable to answer.

Employment Status. Please select the client's employment status

Enrolled in Job Training. Please select the client's job training status.

Work Past 30 Days. Please enter the number of work days the client has had in the past 30 days.

Criminal Justice

Criminal Justice Status. Please select the client's criminal justice status

CDC Identification Number. Please enter the client's California Department of Corrections (CDC) identification number.
* **Response will always be 99902**

Number of – Please enter the number of times the client has been involved with the specified activity in the last 30 days.
How many days in the past 30 days was the client in jail?
How many days has the client been in prison in the past 30 days?
How many times has the client been arrested in the past 30 days?

Parolee Services Network (PSN). Please enter the client's Parolee Services Network status.
* **Response will always be No**

FOTP Parolee. Please enter the client's Female Offender Treatment Program (FOTP) status.
* **Response will always be No**

FOTP Priority Status. Please enter the client's FOTP priority status.
* **Response will always be None or Not Applicable**

Medical/Physical Health

Medi-Cal Beneficiary. Please select whether the client is a Medi-Cal beneficiary.

Last 30 Days. Please enter the number of times the client has been involved with the activity in the last 30 days.
How many times the client visited an emergency room in the past 30 days for physical health problems?
How many days the client stayed overnight in a hospital in the last 30 days for physical health problems?
How many days in the past 30 days the client experienced physical health problems?

Pregnant At Admission. Please select **Yes, No or Not Sure/Don't Know** if the client was pregnant at the time of admission.

Medication Prescribed As Part of Treatment. Please select the medication prescribed for the client as part of treatment. **Please note:** This field is not intended to capture the individual's prescriptions for non-addiction treatment purposes, so providers should only report those medications prescribed by the provider for SUD treatment. In addition, this field is checked against the Master Provider File (MPF). This is to ensure the services being reported are consistent with what the provider is certified or licensed to provide.

Communicable Diseases. Please select the client's status with the disease.
Has the client been diagnosed with Tuberculosis?
Has the client been diagnosed with Hepatitis C?
Has the client been diagnosed with any sexually transmitted diseases?
HIV Tested. Please select the client's HIV testing status and results.
Has the client been tested for HIV/AIDS?
Did the client receive the results of your HIV/AIDS test?

Mental Illness

Mental Illness. Please select **Yes, No or Not Sure/Don't Know** if the client has mental illness

Emergency Room Use/Mental Health. Please enter the number of times in the past 30 days the client received outpatient emergency services for mental health needs.

Psychiatric Facility Use. Please enter the number of days in the last 30 days the client has stayed for more than 24 hours in a hospital or psychiatric facility.

Mental Health Medication. Please indicate the client's mental health prescription medication use in the last 30 days.

Family/Social

Social Support. Please enter the number of days in the last 30 days the client has participated in social support recovery activities.

Current Living Arrangements. Please select the client's current living arrangements.

Living with Someone. Please enter the number of days in the last 30 days the client has lived with someone who uses alcohol or drugs.

Family Conflict Last 30 Days. Please enter the number of days in the last 30 days the client had serious conflicts with their family.
Number of Children. Please enter the **number** of children associated with the client.
How many children the client has aged 17 or younger (birth or adopted) whether they live with you or not?
How many children (birth or adopted) the client has aged five years or younger?
How many of the client's children (birth or adopted) are living with someone else because of a child protection court order?
If the client has children (birth or adopted) living with someone else because of a child protection court order, for how many of these children aged 17 or under have your parental rights been terminated?
Emergency Contact. Please enter the emergency contact information.